ECONOMIC IMPLICATIONS OF HEALTH CARE COORDINATION MODELS

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The stage is set for restructuring a major sector of the state and national economy. Earlier this year, Congress enacted health reform legislation. Federal regulatory agencies now are proceeding with the details of implementing the new law.

A phrase commonly used to describe one of the major aims of the legislation is "bending the cost curve" – reducing the rate of growth in health care expenditures. One way to achieve these cost savings and also benefit the effectiveness of treatments is to improve how care is coordinated among various types of health care providers and care settings.

How this care coordination takes place in Missouri has implications for the economic health of Missouri communities. If it is done by a national health insurance company as part of a health plan with a significant administrative cost margin, more money likely will be directed away from direct patient care than if it is done using provider-based models of care management.

Although the federal reform legislation imposes direct Medicare and Medicaid payment reductions for many services, the overall approach taken by Congress is not to dictate exactly how health care providers must manage their costs. Instead, the health reform law authorizes enhanced federal funding to allow health care providers to explore and refine new delivery and financing models within the Medicaid and Medicare programs. Within these models, providers have some flexibility to determine how best to organize themselves to reach their spending and patient outcome objectives. Examples of such models include bundled payments, medical homes and accountable care organizations. All are designed to create incentives and processes to better coordinate care and improve patient outcomes.

Allowing health care providers to use new delivery and financing models to improve the coordination of patient care differs from the traditional model of insurer-based care management, in which an insurer develops and enforces a prescriptive system of rules to dictate how the provider will manage patient treatments. It appears likely that the traditional model of insurer-based care management will be proposed as a way to control Missouri's Medicaid costs. This would be accomplished through an expansion of Medicaid managed care to regions and populations where it does not now apply.

As the state of Missouri considers whether to expand its use of Medicaid managed care or to promote the development of new delivery models for providers, a number of factors warrant attention.

- The federal health reform law authorizes payment of the costs of many of the provider-focused delivery models at a 90 percent federal/10 percent state rate for the first two years of implementation. This enhanced match rate creates the opportunity to bring in significant amounts of federal money into Missouri based on a small state investment.

- Administrative costs in insurer-based care management plans are significant and divert scarce Medicaid dollars away from patient care, the providers who treat those Medicaid patients, and the communities in which those providers and patients live and work. New federal standards in the health reform law cap insurers' administrative costs by defining a minimum "medical loss ratio" – the portion of total expenses that is directed to patient care – of 80 to 85 percent, depending on the type of plan. The new standards are generating significant consternation among insurers, which apparently view a 15 to 20 percent administrative cost margin as an unattainable standard, at least in the near term. Communities benefit economically by having more of the health care dollar spent and retained locally rather than exported to Wall Street investors of large national health insurers.

- Traditional HMO plans are a dwindling portion of the commercial insurance market in Missouri.

- Medicare managed care plans operating in the Medicare Advantage program have been roundly criticized and financially penalized by Congress for being ineffective, costing the federal government more than it would have paid if their enrollees had been part of the regular Medicare fee-for-service system.

Missouri's economy greatly benefits from the delivery of health care services. The state stands to gain even more economic impact when health care reform is fully implemented because of the large number of newly insured Missouri residents and additional newly insured patients treated here from other states. Keeping the coordination of care with local health care providers ensures Missouri will keep more of the economic benefit within its borders.